# THE POST-PARTUM DOUCHE,

(SHOWING NEW INSTRUMENT)

BY EDWIN PYNCHON, M. D.

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# THE POST-PARTUM DOUCHE.*

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By EDWIN PYNCHON, M.D.

MY experience in the care of women during parturition has caused me to be a firm believer in the practice of thorough asepsis and even of antisepsis. With certain modifications, hereafter noted, I have practically adopted the methods advised by Garrigues. Shortly before the expected delivery I direct the patient to take a warm plunge bath and follow the same by a copious rectal enema and an antiseptic vaginal douche of bichloride, one to two thousand. When practical, a flushing of the colon is far better than simply the rectal enema. Succeeding the delivery my practice has been to remove the secundines by Credé's method, and if there is cause to believe that any material portion thereof has been retained I approve of the introduction of the aseptic hand into the uterus in order to detach and remove the same or learn if such condition exists. The next indication is to secure the expulsion of any remaining small and detached particles or coagulæ of blood, which may be either in the uterine cavity or vaginal folds, and to thoroughly cleanse the same of all debris which would otherwise remain to be dissolved and carried away by the lochial discharge. The only practical way of securing such result is by means of irrigation. Could we always have our patients upon an invalid bed, with opening in the center thereof, it would not be so troublesome to administer a proper douche, but with the limited facilities usually encountered, and with the desire to wet and soil the bed as little as possible, the task assumes more troublesome proportions, particularly if the customary method of turning the patient

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crosswise the bed with buttocks resting upon the side board and feet supported by chairs be adopted. To me it seems reasonable that no thorough cleansing can be secured unless *the cavity to be washed is filled to a degree of moderate distention* so as to separate all apposing surfaces and permit the irrigating fluid to freely touch every portion of the surface to be cleansed, and in order to attain a thorough cleansing such filling and distention should be repeated several times at each *seance*, or until the escaping fluid contains no more debris and is only tinged with blood. This means the necessity for the use of a considerable quantity of the cleansing fluid—generally a gallon at least. Owing to the large quantity employed, the maximum strength thereof need not exceed one to four thousand, and after the first post-partum douche, one to six thousand or eight thousand is preferable, unless in event of septicæmic manifestations the stronger solution may be returned to. I claim that with the ordinary vaginal or intra-uterine tube, be it made of either hard rubber or glass and used as is commonly done, a perfect cleansing cannot be given. W. Gill Wylie says: "Imperfect syringing has frequently resulted in leaving a fetid upper segment of the vagina entirely unwashed, while the antiseptic stream has been limited to the lower third of the canal." (*N. Y. Medical Journal*, June 23, 1883). Dr. T. Gaillard Thomas also recognizes the inefficiency of a too weakly applied douche and says: "A syringe with intermitting jet should be used, which will wash away with gentle force all blood-clots, and reliance should not be placed on the feeble drip of the fountain syringe, the advantages of which are, I think, entirely theoretical." (*N. Y. Medical Journal*, Dec. 15, 1883). This latter writer advises the employment of a douche every four to eight hours for at least ten days succeeding delivery. More enthusiastic disciples of obstetric antisepsis have even recommended continuous irrigation for a similar period of time. (Schücking).

In order to not soil the bedding it is desirable that the cleansing solution shall be carried from the vagina outside of the bed into a proper recepticle.

Feeling the need of a device whereby and wherewith such irrigation as described could be obtained I devised and had constructed the apparatus I here show (see Fig. 1), which has proven to be both simple and efficient in the superlative degree. It consists of three parts; first, a short hard rubber Ferguson speculum of large diameter; second, a soft rubber discharge pipe, about thirty inches in length and of sufficiently large calibre to slip over the flared end of the speculum employed; and third, an ordinary hard rubber vaginal

tip, passing through a small hole on the upper side of the soft rubber discharge pipe near its attachment to the speculum, and connected by a suitable hose with a fountain syringe of large size containing the irrigating fluid, which should be suspended not more than from eighteen to twenty-four inches above the fundus of the uterus. The specula are of three sizes nested, the largest being suitable for use immediately after delivery at full term. The smaller sizes will answer for douches administered when indicated upon any day succeeding the delivery or after a premature birth or miscarriage. In the employment of this device, the soft rubber discharge pipe is first stretched over the flared end of the appropriate speculum, care being taken that the end of the discharge pipe is selected which is provided with the small opening and through which is next passed the hard rubber vaginal tip, which is in turn connected with the fountain syringe already filled with the irrigating fluid. The speculum is next

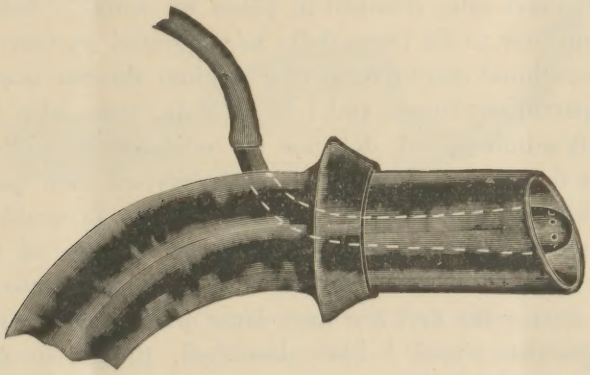

Fig. 1.

entered into the vagina and sufficient pressure is exerted so that its flared end will press against the vulva and prevent the escape of the fluid employed, which, in order to expel the air, is allowed to flow until it begins to escape through the discharge pipe, the lower end of which leads to a convenient slop jar. Now by compressing the soft rubber discharge pipe the solution flowing from the fountain syringe into the vagina is retained, causing the solution to enter the uterus through the dilated os, thoroughly filling all portions of the combined cavities and producing some distention thereof, which, at the proper time, is recognized by a swelling of the discharge pipe between the point compressed and its attachment to the speculum. By now removing pressure from the discharge pipe the retained fluid will escape with a gush carrying with it post-partum

debris. This process should be repeated until the irrigating fluid comes away quite clear and is, I believe, a method of administering a vaginal and intra-uterine douche to the parturient patient which gives less disturbance than any other known means of accomplishing this result with the patient in the recumbent posture. The fountain syringe has certainly a great advantage in points of simplicity and cleanliness over any bulb syringe, and even though its stream ordinarily may be a "feeble drip" when employed with the device described, with the intermitting overflow, the maximum of flushing power is obtained, causing a mechanical as well as a chemical antiseptic action, while the larger quantity of the weaker solution employed gives equally as good results as can a smaller quantity of a stronger solution, for even "pure water, while not destructive to, at least weakens the vitality of many of the bacteria which may infest the post-parturient cavity." After the delivery and use of the douche I apply the protective pad of absorbent cotton, moistened in the 1 to 2,000 bichloride solution, covered with oiled silk, retained in place by suitable bandages and renewed from four to six times daily as suggested by Garrigues.

If the occasional employment of a vaginal douche is advisable at other than parturient times, and I think it is, then why should not appropriately administered douches be indicated daily or even more often after a delivery? I have frequently advised such practice and have never known the patient to make other than favorable criticism thereupon, always acknowledging that after the use of the douche there was a sense of relief—a sensation of increased comfort.

For use during the first few days after delivery I recommend the flushing apparatus which I have described, though as soon as the patient can get up and sit upon the commode, I advise her so to do as by such exercise a natural drainage is secured and additionally owing to the more vertical position of the uterus, a free escape of the antiseptic fluid employed is assured. As soon as the patient can thus sit up I advise the use of a more simple device consisting of an ordinary hard rubber vaginal tip, suitably curved and provided with what is known as a "nozzle bulb" (see Fig. 2), an article manufactured by G. W. Lutz & Co., of Indianapolis, Ind. This bulb is made of soft white rubber and so shaped as to serve as a convenient plug for the external vaginal opening. Regarding the hard rubber vaginal tips I will say that there are several kinds upon the market, one being round from one end to the other, gradually increasing in diameter as the point is approached. Another style, while round at the smaller end, assumes a quadrilateral shape with depressions between the corners as it increases in size towards the point. This latter or corru-

gated form is not suitable for use with the nozzle bulb so the former style described should always be employed and should be bent by heat as shown. By use of this nozzle bulb tip the same results are attained as with the previously described device, to wit:—filling and distention of the vagina and possibly of the uterus, in combination with alternating retention and free discharge, and it would seem that in no other way can the entire internal surface of the vagina be satisfactorily cleansed. With this nozzle bulb tip no air can possibly be introduced if the precaution is taken of allowing the fluid to flow through the tip prior to its introduction. In the treatment of vaginal leucorrhœa much better results can be secured with this tip than when an ordinary vaginal tip is employed, as all of the secretions are first thoroughly removed and afterwards the medicated wash is made to touch all portions of the surface. This latter tip I recommend for general use at all times when vaginal douches are employed, and it is the tip *par excellence* for use when the antiseptic

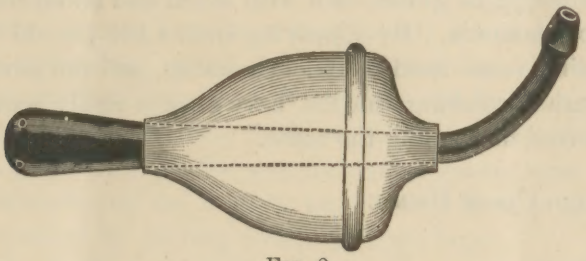

FIG. 2.

douche is administered shortly before delivery, allusion to which has been previously made. A small point in this connection worthy of notice, is that the most desirable style of fountain syringe is one, the several tips accompanying which simply slip into the rubber hose, and all those more elaborate, complicated and expensive kinds wherein the tips are attached by screw or soft rubber cork should be avoided. In the kind I recommend, when the end of the tube becomes too much worn a half inch thereof can be cut off with a scissors and thereby a new and perfect union provided

One possible point of objection might be raised against the devices I have described when used particularly with the post-parturient patient, and that is that through the forced retention of the irrigating fluid and the distention coincident therewith, some of the fluid might be forced through the Falloppian tubes into the peritoneal cavity. When employed in the method described and with the slight fall of fluid not exceeding twenty-four inches as recommended I cannot consider such objection admissable.

When engaged to attend a case of confinement, in order that everything may be in readiness, it has been my custom to furnish the patient with a list of articles to be procured, as follows:

1 fountain syringe No. 4, the tips of which *slip into the hose*.

1 "nozzle bulb," vaginal tip.

1 bed pan.

1 square yard rubber cloth (to protect mattress).

2 clean quart bottles with corks.

2 bedroom sets of washbowl, pitcher, etc.

½ yard oiled silk (for protective pad).

6 yards unbleached muslin (to be washed).

½ dozen *new* safety pins of large size.

1 one-pound roll of absorbent cotton.

1 small bottle of sweet oil and a liberal supply of clean towels.

I also give prescriptions for a three per cent solution of phenol in glycerine, and for a bottle of antiseptic bichloride tablets containing seven and three-tenths grains each with seven and seven-tenths grains of muriate of ammonia. By supplying such a list I avoid the annoyance of finding some needed article missing, and the advantages attained through furnishing the list have always richly repaid for the trouble involved in penning the same.

703 Chicago Opera House.

In closing the discussion Dr. Pynchon said : While my obstetrical practice has not been large, it has been my fortune to meet with my proportion of cases in which the perineum was disposed to be tense and unyielding. In two or three instances I have put in practice a mode of treatment which I do not remember having seen recommended by any of the authorities, and that is, during the interval between the pains, to introduce the finger and give a sort of rolling motion with pressure downward, a species of massage if you please, using considerable force until the tissues relax. I have frequently observed that such procedure has a marked tendency toward overcoming the tenseness of the perineum.

In regard to moistening the protective pad with an antiseptic solution, I will say that one of the principal advantages in using a solution instead of a dry powder, is the fact that it gives a cooling, soothing sensation to the parts, and has been so frequently praised by the patient on account of this quality that I am forced to prefer the wet to the dry pad.

Axis traction forceps have been mentioned: I will say that I have employed a procedure, which I do not remember having seen described in any medical journal, and which has permitted me to secure axis traction with the ordinary forceps. Prior to the introduction of either blade I pass through the two fenestræ a strong tape, and tie it; then, after introducing the forceps and locking them properly, I can get an axis traction by pulling down upon the tape.

As regards curetting, I would not think the curette indicated after full-term delivery, that is, immediately after the delivery or at any time when the os is sufficiently dilated so that the hand can be introduced. I have a curette, copied from one devised by Dr. Geo. W. Webster, with which I have been much pleased. It consists of a curved tube for intra-uterine irrigation and has attached by screw to its point a small sized blunt curette somewhat in the shape of an inverted saucer, and is a valuable instrument for use after a miscarriage.

As regards vaginal examinations, if the hand of the examiner is soiled, one examination is enough to contaminate the patient, but if the examiner's hands are perfectly clean and aseptic, twenty examinations will do no more harm than one. In protracted cases of child-birth it often has a beneficial effect upon the mind of the patient, if these examinations are made every thirty minutes.

I will say that the largest sized speculum which I use is barely two inches in diameter, and it certainly could not injure a vagina but recently stretched to a diameter of about four inches. For use a few

days after full term delivery and after miscarriages I have smaller sizes provided, and I have never known of any difficulty in their introduction.

As regards the mortality in private practice, which is claimed in special cases to be very low, it is not ever thus, and there is always the possibility of septic infection, hence I think after one has read the careful results given by Garrigues, which read like an Arabian Nights entertainment, one can hardly object to taking every available antiseptic precaution in order to avoid the possibility of contamination.